

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Health Resources and Services Administration  
Indian Health Service  
Rockville, Maryland 20857

DEPARTMENT OF INTERIOR  
Bureau of Indian Affairs  
Office of Indian  
Education Programs  
Washington, D.C. 20240

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IHS CIRCULAR NO. 83 -2 - OIEP CIRCULAR NO. 83.1

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OFFICE OF INDIAN EDUCATION PROGRAMS (OIEP) INDIAN HEALTH SERVICE (IHS)  
PROCEDURES FOR PREPARATION AND TRANSMITTAL OF  
HEALTH RECORDS OF AMERICAN INDIAN AND ALASKA NATIVE STUDENTS  
IN OIEP BOARDING SCHOOLS

1. Purpose
2. Background
3. Policy
4. Procedures
5. Appendices

1. Purpose - This circular provides a description of those procedures and responsibilities required by the local IHS service units and BIA agencies that will assure that a student's complete health record is available to school health clinics at the time the student arrives at the boarding school.

2. Background- It is important to the health of the boarding school student that complete health information including history, immunization status, physical examination, special treatment programs, and prohibited activities be known to school health personnel.

3. Policy - OIEP and IHS staff will prepare and transmit complete health information for all students who are applying for boarding school placement according to the procedures as outlined in this circular.

4. Procedures

A. Responsibilities of OIEP Agency<sup>1</sup> or Tribal Education Office.

- (i) A boarding school student applicant contacts an Agency Office or a Tribal Education Office functioning under a P.L. 93-638 contract.

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<sup>1</sup>Agency is defined to include:

- (1) An Area education office directed by an Education Program Administrator,
- (2) An Agency education office directed by an Agency Superintendent for Education (ASE), and
- (3) A field education office served by an Education Specialist or Social Worker, located at an Agency office where there is not an ASE.

- (ii) It is the responsibility of the Agency Office or Tribal Office to request that the local IRS facility, as far in advance of the opening of school as possible, carry out the health appraisal of student applicants and complete these three health documents:
  - a. Report of Medical Examination (HRSA-197; 3-74) - Items 1, 2, 4-8, and 10-18 are to be completed by the Agency or Tribal Office.
  - b. Immunization and Sensitivity Record (HRSA-216; 4-79).
  - c. Consent of Parent or Legal Guardian or Other Person Who, Has Primary Responsibility for the Care of the Child (HRSA-47; 4-81).
- (iii) The Agency or Tribal Office will file completed applications for placement (including the three IRS documents) with the appropriate school 30 or more days before the opening of school.
- (iv) If any or all of the health documents are not available 30 days before the school opens the incomplete application will be transmitted to the school at that time. For practical purposes this means that the health documents must be received by the Agency or Tribal Office no later than the first day of August,, if the health information is to be included with the other documents.
- (VI) Authorization for student travel will not be provided until all the necessary health documents have been received and processed by the Agency or Tribal Education Office.

8. Responsibilities of the Boarding School

- (i) Routine School Admissions. As soon as the three IHS health documents of an accepted student have been received by the school, the administrative staff will transmit them to the Director of the School Health Clinic or designated person.
- (ii) Emergency School Placement
  - a. Emergency school placement is the necessary placement of a student within 24-48 hours which prevents utilizing the normal forms processing procedure.

- b. Within two working days after an emergency school placement of a student, the school administrative office will transmit the following information to the Director of the School Health Clinic:

Name of Student

Home address of Student

Name of Student's home health care facility

- c. It will then be the responsibility of the School health Clinic to obtain the health documents and to carry out any necessary health appraisals.

C. Responsibility of IHS Facilities

- (I) Lines of communication are to be developed between the IHS facility and the OIEP Agency or Tribal Education Office.
- (ii) Clinical services must be provided efficiently and rapidly, and forms processed in a timely fashion so that student's application can be transmitted to the boarding school.
- (iii) The medical examination is to be recorded on the Report of Medical Examination (HRSA-1971, which is to be kept in the patient's clinical chart. On this form items 1, 2, 4-8, and 10-18 are to be completed by the Agency or Tribal Office and the remainder by the health provider or providers. Item 39 pertains to item 38. Items 27, 28, 29 30, 31, 40, 41 and 42 are not required unless already known or specifically indicated. Items 22, 23, 24 should be carried out by a dentist, and items 40 and 42, by an audiologist, audiometric technician or nurse.
- (iv) A student in need of immunizations should be given them at the time of the physical examination, but a signed authorization is of course required. Otherwise the student must return for immunization with relevant "Important Information" forms signed by a parent or guardian. The health provider will, as necessary, bring the Immunization and Sensitivity Record (HRSA-216) up to date.
- (VI) The health provider will secure the signature of a parent or guardian on the Consent Form (HRSA-47) and give copy 3 to the signatory.

- (vI) The IHS staff will either give the following documents directly to the student or the parent/guardian or transmit them to the Agency or Tribal Education Office.
- a. Photocopy of completed Report of Medical Examination (HiSA-197) .
  - b. Photocopy of up-to-date Immunization and Sensitivity Record (HiSA-216).
  - c. Copies 1 and 2 of Consent Form (HRSA-47).

0. Responsibilities of School health Clinic

(1) Routine School Admissions

- a. Within four weeks the available health documents of each student are to be reviewed for completeness and necessary action.
- b. Each student's health program is to be carried forward as indicated (including scheduling of dental, hearing or visual examinations as necessary).
- c. In the case of incomplete or missing reports, the necessary information is to be obtained as described for emergency placements.

(ii) Emergency School Placement

- a. The Director of the School Health Clinic will within one week of notification of an emergency school placement send a written request to the IRS Service Unit. Director (SUD) of the student's home health care facility for:

Prompt forwarding of a copy of the Immunization and Sensitivity Record (WSA-216).

Prompt forwarding of a copy of the Report of Medical Examination (HRSA-1971) as nearly completely 'filled out as local health records will permit.

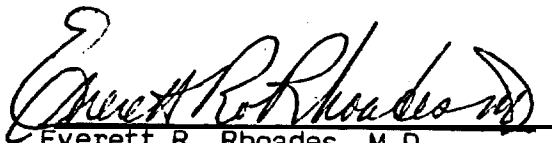
Forwarding of signed copies 1 and 2 of the Consent Form (HRSA-47) as soon as these can be obtained. (Copy 2 is to be transmitted to the school administrative office).

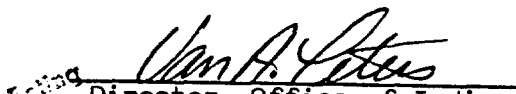
It is recommended that these requests be made also by telephone, and directed to the person (e.g., health Records Chief, Clinical Director, Clinic Nurse, Community Health Nurse) designated by the SUD as responsible for securing and forwarding the information.

- b. If the requested material is not received within three weeks, the Director of the School health Clinic will once again write the SUD, sending a copy of this communication to the IHS Area Director.
- c. The student's health plan is to be carried forward as indicated following review of his records (including scheduling of dental, hearing and visual examinations as necessary). After three weeks if the Report of Medical Examination (HRSA-197) is not yet available, a physical examination should be done.

E- Updating of Immunizations

- (i) Routine Immunization. Needed immunizations may be given only after receipt of the Consent stub(s) of the relevant "Important Information form(s), signed by an Authorized Person. The Authorized Person is the parent or guardian, or the student him/herself if of adult age as defined by the law of the State in which the school is located.
- (ii) Acute Injury. A Tetanus/Diphtheria booster (Td) may be given in emergency situations without formally signed authorization, if recommended by a health provider. It is advisable, however, that an Authorized Person be contacted after the fact and requested to sign for the Immunization.

  
Everett R. Rhoades, M.D.  
Assistant Surgeon General  
Director, Indian Health Service  
Health Resources and Services  
Administration  
Public Health Service  
Department of Health and  
Human Services

  
Van A. Little  
Director, Office of Indian  
Education Programs  
Bureau of Indian Affairs  
Department of the Interior

Form 5-192

April 1964

Code 1 2 3

4 5 6 7

UNITED STATES  
DEPARTMENT OF THE INTERIOR  
Bureau of Indian Affairs

Date received and approved

Boarding school official

APPLICATION FOR ADMISSION TO BOARDING SCHOOL

1. Application of \_\_\_\_\_  
Last Name First Middle
2. Other names by which applicant is known \_\_\_\_\_ Census No. \_\_\_\_\_
3. For admission to: Grade \_\_\_\_\_ School \_\_\_\_\_  
School address \_\_\_\_\_ Date of application \_\_\_\_\_
4. Agency \_\_\_\_\_ Tribe \_\_\_\_\_ Degree Indian \_\_\_\_\_
5. Sex \_\_\_\_\_ Date of birth \_\_\_\_\_ Verified by \_\_\_\_\_  
Month Day Year
6. Birthplace: State \_\_\_\_\_ County \_\_\_\_\_ Town \_\_\_\_\_
7. Name, relationship, and address of person with whom applicant lives and to whom correspondence should be directed \_\_\_\_\_
8. Legal residence: On trust land \_\_\_\_\_ Off trust land \_\_\_\_\_
9. Language spoken in the home \_\_\_\_\_
10. How far does applicant live from a school he can attend? \_\_\_\_\_

11. Grades taught \_\_\_\_\_ Is transportation furnished? \_\_\_\_\_

12. Schools Previously Attended	Address	Dates	Grades Completed	Reasons for Leaving

13. Facts about Parents	Father	Mother
Full name		
Post office address		
If not living, give year of death		
Agency where enrolled		
Tribe, roll number, degree Indian		

14. If parents are not on the rolls, give names of grandparents \_\_\_\_\_

17. No. of brothers: Older \_\_\_\_\_ Younger \_\_\_\_\_ No. of sisters: Older \_\_\_\_\_ Younger \_\_\_\_\_

20. Can applicant pay for transportation to boarding school? \_\_\_\_\_

21. A. I am a high school pupil and I have listed my vocational or special interests below:  
(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

22. I am legally responsible for this applicant and hereby apply for his admission to boarding school. I give my consent to emergency operations, psychiatric treatment, and dental or minor surgery, if such procedure becomes necessary while the child is in school. I also approve such inoculations and treatments in the field of preventive medicine as may be deemed necessary by medical personnel.

Signature (a) \_\_\_\_\_  
Parent Relationship Address

Signature (b) \_\_\_\_\_  
Legal Guardian Relationship Address

Signature of Adult Student \_\_\_\_\_

23. MEDICAL CERTIFICATE

Underscore diseases applicant has had: Chickenpox, diphtheria, measles, tuberculosis, typhoid, scarlet fever, smallpox, whooping cough, trachoma, other \_\_\_\_\_

I, a duly licensed practicing physician, have examined the applicant and find him in proper physical condition to attend school. All deviations from the normal are noted below. The applicant is not afflicted with a communicable disease which would menace the health of other pupils. (If evidence exists of tuberculosis, is it active or arrested according to standards of "T.T.") \_\_\_\_\_

Signed \_\_\_\_\_ M.D. Address \_\_\_\_\_ Date \_\_\_\_\_

CERTIFICATE OF ELIGIBILITY

24. Favorable action is recommended upon this application because the case conforms to the following criteria for boarding school enrollment. (Give all applicable criteria.)

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
For Education

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
For Welfare

CERTIFICATE OF AUTHORIZING ADMINISTRATIVE OFFICIAL

25. I certify that the applicant is \_\_\_\_\_ degree of Indian blood, member of the \_\_\_\_\_ Tribe and the following are attached: medical certificate, birth certificate, student transfer record. I recommend favorable action on this application.

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

ACTION OF AREA OFFICE HAVING JURISDICTION

26. Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Date \_\_\_\_\_  
Reason for disapproval \_\_\_\_\_

Signed \_\_\_\_\_ Concurrence \_\_\_\_\_  
Area Director of Schools Area Social Worker

ACTION OF SECOND AREA OFFICE

27. Forwarded by \_\_\_\_\_ Area Director of Schools \_\_\_\_\_ Area. Date \_\_\_\_\_

RECEIVED, BOARD OF SCHOOLS  
RECEIVED, BOARD OF SCHOOLS  
RECEIVED, BOARD OF SCHOOLS

CLINICAL RECORD - REPORT OF MEDICAL EXAMINATION OF SCHOOL CHILDREN

1. NAME (last, first, middle)				2. NAME OF SCHOOL				3. REGISTRATION NO.					
4. OTHER NAMES USED (last, first, middle)				5. DEGREE OF BLOOD				6. TRIBE					
8. PERMANENT ADDRESS OF PARENT OR GUARDIAN								7. TRIBAL IDENTIFICATION NO.					
9. DATE OF EXAMINATION													
10. PLACE OF BIRTH				11. DATE OF BIRTH				12. AGE		13. SEX		14. OTHER CLINIC OR SCHOOL ATTENDED	
15. FATHER'S NAME				16. PLACE OF BIRTH				17. MOTHER'S MAIDEN NAME				18. PLACE OF BIRTH	
19. SIGNIFICANT FAMILY HISTORY (List tuberculosis, venereal disease, diabetes, epilepsy, trachoma in family. Also, if parents not living, indicate cause of death.)													

20. SIGNIFICANT PERSONAL HISTORY (List, with dates where possible, history of rheumatic fever, chorea, tuberculosis, asthma, convulsive disorder, diabetes, otitis media, pneumonia, trachoma, other serious illness or hospitalization and menstrual history.)

21. SIGNIFICANT SOCIAL HISTORY

22. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively.) 0 - Restorable teeth      X - Missing teeth      (6x8) - Fixed bridge, brackets I - Non-restorable teeth      XXX - Replaced by dentures      to include abutments.																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES																																																					
<table border="1"> <tr> <td>R</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>L</td> </tr> <tr> <td>I</td><td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td><td>T</td> </tr> <tr> <td>H</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																																R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L	I	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	H	
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23. DATE OF DENTAL EXAMINATION								24. SIGNATURE OF EXAMINER																																																													

LABORATORY FINDINGS

25. URINALYSIS								26. HEMATOCRIT OR HEMOGLOBIN									
A. SPECIFIC GRAVITY				D. MICROSCOPIC													
B. ALBUMIN																	
C. SUGAR																	
27. SEROLOGY (Specify test used and result.)								28. EKG		29. BLOOD TYPE AND RH FACTOR				30. OTHER TESTS			
31. CHEST X-RAYS (Place, date, film number and result.)								32. NAME OF FACILITY OR CLINIC									



# **MEASUREMENTS AND OTHER FINDINGS**

<b>33. HEIGHT</b>	<b>34. WEIGHT</b>	<b>35. BUILD</b> <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESSE	<b>36. BLOOD PRESSURE (Arm at heart level)</b> A. Systolic      B. Diastolic
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<b>37. PULSE (Arm at heart level)</b> A. Sitting B. After exercise	<b>38. VISION</b> Right 20/      Corr. to 20/ Left 20/      Corr. to 20/	<b>39. DATE OF EXAMINATION AND SIGNATURE OF EXAMINER</b>
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<b>40. HEARING (Indicate test used and findings)</b> Right                      Left	<b>41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score.)</b>
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<b>42. DATE OF EXAMINATION AND SIGNATURE OF EXAMINER</b>	<b>43. NOTES (Describe every abnormality in detail. Enter pertinent Item Letter before each comment.)</b>
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**43. CLINICAL EVALUATION (Check each Item in appropriate column.)**

NORMAL	AB-NORMAL	NOT EVAL. UATED	ITEM
			A. HEAD, FACE, NECK AND SCALP
			B. NOSE
			C. SINUSES
			D. MOUTH AND THROAT
			E. EARS - GENERAL
			F. DRUMS (Perforation)
			G. EYES - GENERAL (Include examination for trachoma)
			H. OPHTHALMOSCOPIC
			I. PUPILS AND OCULAR MOTILITY
			J. LUNGS AND CHEST
			K. HEART AND VASCULAR SYSTEM
			L. ABDOMEN AND VISCERA (Include hernia)
			M. ANUS AND RECTUM
			N. ENDOCRINE SYSTEM (Include indication of puberty)
			O. G-U SYSTEM
			P. UPPER EXTREMITIES
			Q. FEET AND LOWER EXTREMITIES
			R. SPINE, OTHER MUSCULOSKELETAL
			S. IDENTIFYING BODY MARKS, SCARS, TATTOOS
			T. SKIN LYMPHATICS
			U. NEUROLOGIC (Equilibrium included)
			V. PSYCHIATRIC (Specify any known personality deviation)

**45. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with Item Letters. Include allergies, especially drug allergies.)**

**46. RECOMMENDATIONS (Further specialist examinations and follow-up indicated. Specify.)**

<b>47. SIGNATURE OF EXAMINING PHYSICIAN</b>	<b>48. DATE</b>
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## IMMUNIZATION AND SENSITIVITY RECORD

I have read the information contained in the Important Information Forms noted next to my signature below or on the reverse side. I have had the opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for whom I am authorized to make this request.

Vaccine	Signature Date	Signature of Person to Receive Vaccine or Person Authorized to Make Request	Form Number and Date	Mfg. and Lot No.	Vaccination Date	Vaccine Site	Signature of Provider
#1 DTP							
#2 DTP							
#3 DTP							
#4 DTP							
#5 DTP							
<b>POLIO (Circle Type)</b>							
#1 Sabin (TOPV)							
Salk (IPV)							
#2 Sabin (TOPV)							
Salk (IPV)							
#3 Sabin (TOPV)							
Salk (IPV)							
#4 Sabin (TOPV)							
Salk (IPV)							
#5 Sabin (TOPV)							
Salk (IPV)							
<b>DT or Td</b>							
<b>TETANUS</b>							
<b>MMR</b>							
<b>MEASLES</b>							
<b>MUMPS</b>							
<b>RUBELLA</b>							

Patient Identification

Vaccine	Signature Date	Signature of Person to Receive Vaccine or Person Authorized to Make Request	Form Number and Date	Mfg. and Lot No.	Vaccination Date	Vaccine Site	Signature of Provider
INFLUENZA							

**PNEUMOCOCCAL VACCINE**


**OTHERS**


**TUBERCULIN TEST**

Date Given	Signature of Provider	Date Read	Results	Signature of Provider	Date Given	Signature of Provider	Date Read	Results	Signature of Provider

**OTHER SENSITIVITY TESTS (Cocci, etc.)**

Date Given	Signature of Provider	Date Read	Results	Signature of Provider	Date Given	Signature of Provider	Date Read	Results	Signature of Provider

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE  
INDIAN HEALTH SERVICE

**CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON <sup>1/</sup>  
WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD**

(Before completing this form, please read information on reverse side.)

Name of Student \_\_\_\_\_ Birth Date \_\_\_\_\_

I (We), \_\_\_\_\_  
have read the Consent Form for the Indian Health Service to arrange for or to provide the following health services for this child:

1. Health care including medical examinations, routine laboratory studies/x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental care.
3. Mental health services including evaluation and treatment as necessary.
4. Emergency health care for accidents or illness.
5. Transportation of the child to and/or from another health facility for these services.

☐ I hereby give consent for all of the above services.

☐ Exceptions or Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_ Valid Until: \_\_\_\_\_

PLEASE RETURN THIS FORM TO THE SCHOOL

(The third page of this form is for you to keep)

<sup>1/</sup> Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

## DEFINITIONS

### 1. HEALTH CARE:

Health care is the provision of health services of preventive, diagnostic, therapeutic and/or rehabilitative nature that do not involve major surgical procedures.

The purpose of a medical examination is to appraise the child's health and physical condition. The medical examination consists of two parts: in the first part, questions are asked relative to the health, present and past, of the child and his/her parents; in the second part, a thorough examination is made of the child's body, including weight, height, blood pressure, vision, and hearing.

Laboratory studies include tests of urine and blood.

X-rays are taken when necessary to see if there is any abnormality within the body.

A skin test consists of the injection into the skin of about a drop of a substance such as "tuberculin" or "coccioidin." By means of these tests and x-rays of the chest the physician determines whether the patient has or has had tuberculosis or valley fever.

### 2. DENTAL CARE:

Dental care begins with the dental examination, which consist of (a) examining teeth, gums, tongue, and other parts of mouth with dental mirror and explorer (probe) and (b) taking dental x-rays as needed.

Routine dental care includes those services necessary to prevent the loss of teeth, such as cleaning the teeth, applying fluoride to the teeth, filling decayed teeth, and pulling teeth in order to prevent infection or clear up existing infection.

Necessary emergency dental care consists of those services that cannot be deferred without endangering the child's health or life, such as the relief of pain, the clearing up of infection, and the control of bleeding.

### 3. MENTAL HEALTH SERVICES:

Mental health services include psychological and psycho-educational testing, psychiatric evaluation, and consultation or assessment by mental health professionals. The information obtained is used to determine if it is appropriate or necessary to develop a treatment program for the child.

### 4. EMERGENCY HEALTH CARE:

Emergency health care includes surgical and/or non-surgical procedures that cannot be deferred without endangering the child's health or life. Surgical procedures that can be deferred are not authorized by the consent in this form. In such cases the specific authorization for surgery from the parent or legal guardian is required.

## PRIVACY ACT PUBLIC LAW 93-579

The Privacy Act of 1974 establishes procedures to protect information which the Federal government collects about individuals. The basic authority for delivery of Health is the 25 USC 13, commonly referred to as the Synder Act.

Public Law 93-638 authorizes the Public Health Service to enter into contracts and grants with tribal organizations to carry out any Indian Health Service functions, authorities and responsibilities. Indian Health Care Improvement Act, Public Law 94-437 expands the provision of health services to Indians based on the concept of Indian self-determination.

The Indian Health Service personnel will not tell anyone what is in a medical record without the patient's written consent or the consent of a person with authority to act on behalf of the child. With a few exceptions, copies of a record, in part or total, may be disclosed to:

- To state, local or other authorized, organizations which provide health services to American Indians and Alaskan Natives for the purpose of planning for or providing such services; billing third parties for the payment of care, and reporting results of medical examination, care and treatment.
- To individuals and organizations deemed qualified by the Secretary to carry out specific research solely for the purpose of carrying out such research.
- To federal and non-federal school systems which serve American Indian and Alaska Native children for the purpose of student health maintenance. We release to school personnel only the health care information that affects the health, safety, and learning needs of the student while attending school.
- To the Bureau of Indian Affairs and their contractors for the identification of American Indian and Alaska Native handicapped children in support of P.L. 94-142, the Education for All Handicapped Children Act of 1975.
- To organizations deemed qualified by the Secretary to carry out quality assessment, medical audits or utilization.
- To authorized organizations or individuals for conduct of analytical and evaluation studies sponsored by the Indian Health Service.
- To a Congressional office in response to an inquiry from that office made at the request of the subject individual.
- To federal, state and local law enforcement agencies as may be required by law.

Indian Health Service personnel will not tell anyone what is in your child's medical record without your written permission, without either notifying you or publishing a public notice in the Federal Register describing a new category of necessary disclosure. If you have any questions about this form or health record, you may ask an Indian Health Service doctor or nurse to explain it to you.



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**PUBLIC HEALTH SERVICE  
HEALTH SERVICES ADMINISTRATION**

**INDIAN HEALTH SERVICE**

**Dear Parent or Guardian:**

The Indian Health Service is asking you to complete and sign the attached consent form in order to arrange for or provide health services for your child/children while in attendance at school. This includes medical and dental care (including emergency services when necessary).

The attached Consent Form for School Health Services provides information about the services available while your child attends school. If you desire to share your responsibility for the health care of your child, the Indian Health Service must have a signed consent form in his/her health record. You have the right to approve the entire consent form or write your exceptions or special instructions in the space provided.

The Indian Health Service will collect the information for proper health care and use the information to treat your child or for the purposes described on the back of the consent form.

You are urged to sign this consent form which is for the current school year. A new form will be required for each school year. Please return this form to the school or the local IHS clinic.

Thank you very much for your assistance.

Attachment

\_\_\_\_\_  
PHS Indian Health Service Clinic